

THE INDIVIDUAL PLAN OF CARE

The purpose of the individual plan of care is to assist child care staff to understand and document modification of their programming for children with special needs (including physical, mental, behavioral, developmental, or nutritional conditions or needs). This meets the requirements of the Washington Administrative Code (WAC 7010 (1) (e) (h)) for Child Care Centers and the Americans with Disabilities Act. This allows staff to focus on inclusion and the success of each child.

Staff will be able to refer to this plan for children with special and/or medical needs. Individual health care plan forms for children with life-threatening allergies, diabetes, asthma, seizures and other medical issues are available from your Child Care Public Health Nurse Consultant.

Each individual plan of care should be developed collaboratively with the parent/guardian, as well as any other professionals that the parent/guardian would like to include (e.g., school personnel, health care professionals).

The plan should include the following:

- Child's name & birth date
- Emergency contacts
- Diagnosis
- Strengths/abilities/interests
- A copy of the IEP or IFSP, if available
- · Health care professionals working with the child
 - Remember to get a written consent from the parent/guardian if you plan to consult with these professionals.
- Emergencies that might arise and how to handle them
- Medications (even if taken at home)
 - Remember to make provisions to store a three-day supply of medication in order to meet disaster preparedness guidelines. (WAC 388-295-5030)
- Accommodations (e.g., environmental, sleeping, eating, toileting, behavioral)
- Special materials/equipment (e.g., math manipulatives, hearing aid, calculator for homework)
- Training staff might need
- Signatures (director, parent/guardian and health care provider, if needed)



Here is a list of questions that may be helpful to ask parents when writing the individual plan:

- 1) What are the health problems or concerns about your child?
- 2) Does the staff need to be trained in any special emergency procedures that your child might need?
 - What happens to the child when a crisis occurs?
 - What procedures would you like the staff to follow during these crises?
 - What steps, if any, would you like the staff to take in preventing a crisis?
- 3) Is your child taking any medications regularly?
 - If yes, please list medication and schedules, and any important directions.
- 4) Does your child require any accommodations in the following areas (diet, toileting, special equipment, change in activity, and other help)?
- 5) What other information can you share about the strengths, assets and interests of your child?
- 6) Do you have any special hints about techniques you know work well with your child?
- 7) How else do you think we can support your child and help him/her have a successful day?

For a child that has no diagnosis, but is showing signs of a behavior problem – keep a record of behavior as follows:

Date/ Child's Name	Trigger – What Happened Before the Behavior	The Behavior – What Happened	Intervention - What You Did	Outcome - Did the Intervention Work?	If Not, What Will You Try Next Time the Behavior Occurs (Evaluation and
	Deliavioi				Plan)?

This record will show documentation of behavior management, should you need a plan at a later time.

